



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
**DEPARTMENT OF STATE**  
DIVISION OF PROFESSIONAL REGULATION  
**BOARD OF NURSING**

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: DPR.DELAWARE.GOV

## COLLABORATIVE AGREEMENT INFORMATION FOR ADVANCED PRACTICE NURSES

### INSTRUCTIONS

To practice in Delaware, APNs are required to have a collaborative agreement (Section 8.4 of the Board's [Rules and Regulations](#)) at **each** individual business/practice where they will be practicing. Although you may apply for an APN license without a collaborative agreement, you are not permitted to *start practicing* as an APN in Delaware until your APN license or a temporary permit has been issued **and** you have a collaborative agreement. Similarly, to apply for prescriptive authority for non-controlled substances, APNs must have a collaborative agreement for **each** business/practice where they will prescribe. This is also a requirement for a controlled substance registration.

Use this form when you already hold a Delaware APN license **and** any of the following applies to you:

- A collaborative agreement has terminated.
- You had no collaborative agreement when you applied for or received your APN license, but you now have an agreement.
- You need to report a new or additional collaborative agreement or any other collaborator change.

If you have not yet applied for your Delaware APN license, see [Application for Licensure as an Advanced Practice Nurse](#). If you have an APN license but not prescriptive authority, file the [Advanced Practice Nurse Application for Independent Practice/Prescriptive Authority](#).

### IDENTIFYING AND CONTACT INFORMATION

1. Full Name: \_\_\_\_\_  

Last
First
Middle
Maiden
2. Do you hold an active Delaware Advanced Practice Nurse license? Yes  No  If yes, enter license number:  
L\_\_\_\_ - \_\_\_\_\_.
3. If you did not enter a license number above, enter your Social Security Number: \_\_\_\_\_
4. Address: \_\_\_\_\_  

City
State
Zip
5. Phone: \_\_\_\_\_ Email: \_\_\_\_\_  

daytime
evening or cell

### AGREEMENT CHANGES REPORTED

6. Are you reporting the end of a collaborative agreement? Yes  No  If yes, enter the following information about the **terminated** agreement:  
Name of Former Collaborator: \_\_\_\_\_  
Business/Practice Name: \_\_\_\_\_  
Business/Practice Address: \_\_\_\_\_  
Indicate why the agreement terminated:  
 I am no longer employed at this business/practice.  
 My former collaborator is no longer employed at this business/practice.  
 Other – explain: \_\_\_\_\_

Do you still have a collaborative agreement with someone else at this business/practice? Yes  No   
 If yes, who? \_\_\_\_\_ *If you have not previously reported this agreement, provide the information in Question 7.*

7. Are you reporting one or more new or additional collaborative agreements? Yes  No  If yes, complete the following information about the new or additional agreement(s). Check all that apply:
- I did not have a collaborative agreement when I applied for APN licensure, but I now have a new collaborator(s).
  - I did not have a collaborative agreement when my APN license was issued but I now have a new collaborator(s).
  - I have begun practicing at an *additional* business/practice and have a new collaborator there.
  - I am practicing at the same business/practice I previously reported, but my collaborator there has changed.
  - Other - explain: \_\_\_\_\_
8. Complete the following information about the each individual business/practice where you have a new, additional or revised collaborative agreement. Do **not** list multiple locations of the same business/practice. *If you need more room, enclose a separate sheet with the same information.*

DELAWARE BUSINESS/PRACTICE NAME	IF YOU HAVE PRESCRIPTIVE AUTHORITY, WILL YOU BE PRESCRIBING AT THIS LOCATION?
	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Submit a completed and signed *Collaborative Agreement* form from each new or additional collaborator. Refer to instructions regarding who must sign the form.**

9. Do you agree to report to the Board office any changes in the person, facility or healthcare system with which you have a collaborative agreement? Yes  No

***I affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.***

**Signature of Advanced Practice Nurse:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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### COLLABORATIVE AGREEMENT

- Submit a completed and signed *Collaborative Agreement* form from each new or additional collaborator.
- The APN must sign the top box. The collaborator/designee must sign the CERTIFICATION OF COLLABORATIVE AGREEMENT below it.
- If the APN does not have prescriptive authority or has prescriptive authority only for non-controlled substances, a designee of the health care system or a DE-licensed physician, podiatrist or dentist may sign the form. However, if the APN has a controlled substance registration, a DE-licensed physician, podiatrist or dentist ***must*** sign the form.

#### BUSINESS/PRACTICE INFORMATION - *To be completed and signed by APN*

Advanced Practice Nurse Name: \_\_\_\_\_ Delaware License No: L\_\_\_\_ - \_\_\_\_\_

Business/Practice Name: \_\_\_\_\_

**Location** Address: \_\_\_\_\_  
(If more than one location, enter main location. No PO Box!)

\_\_\_\_\_ DE \_\_\_\_\_ Business Phone: \_\_\_\_\_  
City State Zip

Name of Collaborator at this Business/Practice: \_\_\_\_\_

Select the item that describes your collaborative agreement at this business/practice (check all that apply):

- A - I have healthcare facility approved clinical privileges.
- B - I have a healthcare facility approved job description.
- C - I have a written agreement with a physician, dentist, podiatrist, or licensed Delaware healthcare delivery system.

Will you be prescribing controlled substances at any location of this business/practice? Yes  No

Do you agree to report to the Board office any changes in the person, facility or healthcare system with which you have a collaborative agreement? Yes  No

***I affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.***

Signature of Advanced Practice Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

#### CERTIFICATION OF COLLABORATIVE AGREEMENT - *To be completed and signed by collaborator/designee*

**I certify that a process for consultation and referral of clients has been established with the APN named above. I understand that this agreement remains in place until either the APN or collaborating practitioner/health care system notifies the Delaware Board of Nursing in writing that the collaborative agreement is terminated.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Person Certifying to the Collaborative Agreement: \_\_\_\_\_

Are you a Delaware-licensed physician, podiatrist or dentist? Yes  No

• If yes, enter your Delaware License No: \_\_\_\_\_

• If no, enter title and healthcare system you represent: \_\_\_\_\_